92-881

No. _____

Supreme Court, U.S.
FILED
NOV 16 1992
OFFICE OF THE CLERK

In The
Supreme Court of the United States
October Term, 1992

JAMES MAXA AS PERSONAL REPRESENTATIVE
FOR THE ESTATE OF NEIL MAXA,

Petitioner,

VS.

JOHN ALDEN LIFE INSURANCE COMPANY,

Respondent.

On Petition for Writ of Certiorari to
The United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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STATEMENT OF THE QUESTION PRESENTED FOR REVIEW

Under de novo review of ambiguous language in a ERISA governed health insurance plan, must the estate of a deceased plan participant prove the decedent's reliance on that confusing language to enforce a benefit claim?

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JURISDICTION

Petitioner seeks a Writ of Certiorari for review of a decision of the United States Court of Appeals for the Eighth Circuit dated August 17, 1992.

This Court has jurisdiction to review that judgment by Writ of Certiorari pursuant to 28 U.S.C. § 1254(1).

THE STATUTE INVOLVED IN THIS CASE

§ 1022. Plan description and summary plan description
(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(2) A plan description (containing the information required by subsection (b)) of any employee benefit plan shall be prepared on forms prescribed by the secretary, and shall be filed with the Secretary as required by section 1024(a)(1) of this title. Any material modification in the terms of the plan and any change in

the information described in subsection (b) shall be filed in accordance with section 1024(a)(1)(D) of this title.

(b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

29 U.S.C. § 1022.

STATEMENT OF THE CASE

In 1984, Neil Maxa became insured under a group health insurance plan administered by Respondent John Alden Life Insurance Company ("John Alden") providing him with comprehensive medical and hospitalization coverage.[1] Maxa died in 1989 at the age of 68. Petitioner, Estate of Neil Maxa ("Maxa Estate"), submitted Maxa's medical and hospitalization expenses arising from his life-ending illness to John Alden for payment under the plan. John Alden denied coverage on the ground that those expenses would have been covered by Medicare. Maxa, for reasons unknown, had not applied for Medicare when he became eligible at age 65.

John Alden's denial of benefits was based upon a coordination of benefits provision contained in its certificate of group coverage. That provision reads:

> Coordination Of Benefits
>
> We will coordinate your medical and dental benefits (if applicable) with benefits payable under other plans. The other plans are those which provide benefits or services in connection with medical or dental or treatment through:
>
> . . .
>
> 4. Medicare (Parts A & B) when you are eligible for Medicare coverage. For purposes of determining your Medicare benefits, you will be deemed to have enrolled for all coverages for which you are eligible

[1] Neil Maxa was also president of the small company that employed him and two other people. The parties disputed below whether John Alden or Maxa's Company was plan administrator. That issue was never resolved by the courts below; however, John Alden has acknowledged its responsibility for the language at issue.

> under Medicare (Parts A & B), whether or not you actually enroll.
>
> Coordination means that benefits are paid so that no more than 100 percent of your necessary, reasonable, and customary expenses will be covered under the combined benefits from all plans.

Maxa's Estate appealed John Alden's denial of benefits, contending that the provision was ambiguous and misleading. John Alden denied the appeal on November 6, 1989. On July 17, 1990 the Maxa Estate filed this action pursuant to 29 U.S.C. § 1132(a)(1) in United States District Court for the District of Minnesota. The district court had jurisdiction pursuant to 29 U.S.C. § 1132(e)(1). That court granted summary judgment for John Alden on the parties' cross motions. Maxa's Estate appealed and on August 17, 1992 the Eighth Circuit affirmed.

ARGUMENT

To further ERISA's purpose of protecting participants in employer sponsored benefit plans, 29 U.S.C. § 1022(a) requires plans to provide participants with a "summary plan description." The summary plan description "shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan ..." 29 U.S.C. § 1022(a)(1). That statute specifies that the summary plan description "shall contain" information on "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits ..." 29 U.S.C. § 1022(b).

Regulations promulgated by the United States Department of Labor further detail the standard:

> (a) Method of presentation. The summary plan description shall be written in a manner calculated to be understood by the average plan participant and shall be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. In fulfilling these requirements, the plan administrator shall exercise considered judgment and discretion by taking into account such factors as the level of comprehension and education of typical participants in the plan and the complexity of the terms of the plan. Consideration of these facts will usually require limitation or elimination of technical jargon and of long, complex sentences, the use of clarifying examples and illustrations, the use of clear cross references and a table of contents.
>
> (b) General format. The format of the summary plan description must not have the effect of misleading, misinforming or failing to inform participants and beneficiaries. Any description of exceptions, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure, or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations.

29 C.F.R. § 2520.103-3.

The language at issue fails to meet these standards. For the average plan participant, the meaning of the term

"coordination" in John Alden's description may seem fairly clear from the definition:

> Coordination means that benefits are paid so that no more than 100 percent of your necessary, reasonable, and customary expenses will be covered under the combined benefits from all plans.

This language clearly means that no more than 100 percent of the health care expenses will be paid, but says nothing about payment of less than 100 percent. It does not use commonly understood words such as reduced, diminished, or limited.

> Subparagraph 4 of that provision states:
> For purposes of determining your medicare benefits, you will be deemed to have enrolled for all coverages for which you are eligible under Medicare (Parts A & B), whether or not you actually enroll.

The language stating that the participant will be "deemed to have enrolled" is at the very least obscure. The language does not indicate, for example, who deems the participant to have enrolled in Medicare. A participant might reasonably understand that Medicare automatically deems him to be covered once he becomes eligible, whether or not he actually enrolled. It does not say that John Alden will deem the participant to have Medicare coverage and thereby greatly reduce coverage under its plan. An average plan participant could reasonably read this language without understanding that it reduces benefits to below 100 percent.

Both the district court and the United States Court of Appeals for the Eighth Circuit criticized the confusing language in John Alden's coordination of benefits provision. The district court stated:

> In the instant case, the court has grave doubts that the documents submitted to Neil Maxa met

> ERISA's requirements for Plan Summary Descriptions regarding the coordination of Medicare benefits. The materials are questionable because they arguably do not clearly state that a reduction to below 100% coverage is the consequence of the coordination policy.

April 17, 1991, Decision of Paul A. Magnuson, United States District Court Judge (Appendix at A5; emphasis in original and footnote omitted). The Eighth Circuit shared the district court's doubts that the language did not meet the standards of 29 U.S.C. § 1022(a)(1). (Appendix at A16). Nevertheless, both courts denied recovery to Maxa's Estate because it did not present evidence of Neil Maxa's reliance upon the faulty language.[2]

At both the district and circuit courts in this case, Maxa's Estate asked the courts to abandon the reliance requirement and to apply the traditional rule of construction for contracts and insurance policies. Called the rule of contra proferentem, that rule strictly construes ambiguities against the drafter of an insurance policy and in favor of the policy holder. In Mutual Life Insurance Co. of New York v. Hurni Packing Co., 263 U.S. 167, 174 (1923) this Court stated the rule as follows:

> The rule is settled that in case of ambiguity that construction of the policy will be adopted which is most favorable to the insured. Language employed is that of the company and it is consistent with both reason and justice

[2]Although the Eighth Circuit refers to a reduction in Maxa's premium, evidence was also presented showing that the premiums for other employees simultaneously increased. The monthly premium paid by Maxa's employer fell from $530.82 to $515.26 the month he turned 65. No evidence showed Maxa personally knew of the change in premium. Even if he did, it would not be adequate notice.

> that any fair doubt as to the meaning of its own words should be resolved against it.

See also, First National Bank v. Hartford Fire Insurance Co., 95 U.S. 673, 678-79 (1877); Imperial Fire Insurance Co. v. Coos County, 151 U.S. 452, 462-63 (1894). This rule has been applied outside of the ERISA context uniformly in the state and federal courts.

Under the Eighth Circuit approach to ERISA claims challenging ambiguous plan language, a plan participant must show that he or she actually relied on the ambiguity. This rule arises from a line of Eighth Circuit cases dating to 1984: Monson v. Century Manufacturing Co., 739 F.2d 1293, 1302 (8th Cir. 1984); Lee v. Union Electric Co., 789 F.2d 1303, 1308 (8th Cir. 1986), cert. denied, 479 U.S. 962 (1986); Anderson v. Alpha Portland Industries, Inc., 836 F.2d 1512, 1520 (8th Cir. 1988), cert. denied, 489 U.S. 1051 (1989). Based on this precedent, the Eighth Circuit held that the Maxa Estate had no claim without proof of Neil Maxa's reliance on the ambiguity. (Appendix at A17). This decision should not stand.

I. THE DECISION BELOW CONFLICTS WITH THIS COURT'S DECISIONS.

The Eighth Circuit recognized that John Alden's plan did not confer discretion on the administrator or fiduciary, and therefore review of John Alden's decision to deny benefits to the Maxa Estate should be conducted de novo. (Appendix at A15). Its application of de novo review to require proof of reliance, however, conflicts with this Court's decision in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989). In Bruch, this Court analogized ERISA to the principles of trust law to explain why

interpretation of plan terms is not a discretionary function subject to review on an arbitrary and capricious standard. In explaining de novo review, this Court stated:

> As they do with contractual provisions, courts construe terms in trust agreements without deferring to either party's interpretation. "The extent of the duties and powers of a trustee is determined by the rules of law that are applicable to the situation, and not the rules that the trustee or his attorney believes to be applicable, and by the terms of the trust as the court may interpret them, and not as they may be interpreted by the trustee himself or by his attorney." 3 W. Fratcher, Scott on Trusts § 201, at 221 (emphasis added).

Id. 489 U.S. at 112.

Under the Eighth Circuit's decisions, a claimant who interprets ambiguous plan language and then relies upon that interpretation is entitled to recover benefits. In effect, the Eighth Circuit defers to the participant's interpretation of ambiguous language. Bruch's instruction, however, is that de novo review is not a subjective inquiry. Courts should not defer "to either party's interpretation" when construing an ERISA governed plan. Id., 489 U.S. at 112.

Moreover, this court has repeatedly stated that ERISA was enacted "to promote the interest of employees and their beneficiaries in employee benefit plans." Id. at 113, quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983) and citing 29 U.S.C. § 1001. Prior to the adoption of ERISA, health insurance claimants were not required to establish detrimental reliance on ambiguous language in an insurance policy. Under the contra proferentem rule, if the policy language could reasonably be interpreted in favor of coverage, then that interpretation governed. The Eighth Circuit approach imposes the additional element of

reliance on claims governed by ERISA. (Appendix at A17-18). As a result, claimants such as Maxa's Estate are afforded less protection than they enjoyed before ERISA was enacted. This method of de novo review directly conflicts with both ERISA's purpose and this court's holding in Bruch.

II. THE DECISION BELOW CONFLICTS WITH DECISIONS OF OTHER CIRCUIT COURTS.

The Eighth Circuit's rejection of the contra proferentem rule and retention of the reliance requirement in this case is consistent with its decision in Brewer v. Lincoln National Life Insurance Co., 921 F.2d 150, 153 (8th Cir. 1990).[3] (Appendix at A18). Both of those decisions conflict with the decisions of the Second, Ninth and Seventh Circuits.[4] Kunin v. Benefit Trust Life Insurance Co., 910 F.2d 534 (9th Cir. 1990), cert. denied ___ U.S. ___, 111 S. Ct. 581 (Dec. 10, 1990), reh'g denied __U.S.__ (Jan. 22, 1991); Masella v. Blue Cross & Blue Shield of Connecticut, Inc., 936 F.2d 98 (2nd Cir. 1991); Phillips v. Lincoln National Life

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[3]The decision in this case, however, appears inconsistent with the Eighth Circuit's decision in Delk v. Durham Life Insurance Co., 959 F.2d 104, 105-06 (8th Cir. 1992). In Delk, the Eighth Circuit did apply contra proferentem in the ERISA context. Although the facts and the court's reasoning in Delk are not fully explained, it does not appear that the Eighth Circuit applied its reliance requirement. Delk was decided five months before this case, and it is unclear how these two decisions can be reconciled.

[4]The First and Third Circuits also have held that contra proferentem will not apply in most ERISA cases, but have taken no position on its application to insurance claims. Taylor v. Continental Group Change in Control Severance Pay Plan, 933 F.2d 1227, 1233 (3rd Cir. 1991). Allen v. Adage, 967 F.2d 695, 701 (1st Cir. 1992).

Insurance Co., No. 91-3477, 1992 WL 297985, at * 23 (7th Cir. Oct. 21, 1992).[5]

Decided before Brewer, the Ninth Circuit applied the contra proferentem rule to ambiguous language in an ERISA governed plan. Kunin v. Benefit Trust Life Insurance Co., 910 F.2d 534. The court stated:

> There is room for disagreement as to whether a uniform federal rule of construction applies when we construe an ambiguous provision in an ERISA insurance contract or whether the applicable state rule of construction is incorporated into federal law for that purpose. However, we need not decide that question here, because the rule of contra proferentem would control in either event. As we noted above, the contra proferentem rule is followed in all fifty states and the District of Columbia, and with good reason. Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common lay person to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament. Were we to promulgate a federal rule, we would find these common-sense rationales sound. In deed, it would take a certain degree of arrogance to controvert an

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[5]In addition, two district courts from other circuits have followed Kunin and/or Masella to apply contra proferentum to ERISA governed policy language. Nesom v. Brown and Root, USA, Inc., 790 F. Supp. 123 (D. La. 1992); Germany v. Operating Engineers Trust Fund, 789 F. Supp. 1165 (D. D. C. 1992).

> opinion held with such unanimity in the various states and to adopt a contrary view as the federal rule. We hold, therefore, that the rule of contra proferentem applies to the case at bar, regardless of whether it applies as a matter of uniform federal law or because federal law incorporates state law on this point.

Id. at 539-40 (footnote omitted).

When the Second Circuit reached this issue in 1991, it also applied the contra proferentem rule to ERISA governed plan language. Masella v. Blue Cross & Blue Shield of Connecticut, 936 F.2d 98. It reasoned:

> [W]e believe that application of this rule of interpretation to de novo review of ERISA insurance plans is an appropriate implementation of the congressional expectation that the courts will develop a "federal common law of rights and obligations under ERISA-regulated plans." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. at 110-11, 109 S. Ct. at 954 (citing 129 Cong. Rec. 29942 (1974) (remarks of Sen. Javits)) (other citations omitted). To ignore the effect of this rule "would require us to . . . afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted," a result that would be at odds with the congressional purposes of promoting the interests of employees and beneficiaries and protecting contractually defined benefits.

Id. at 107.

The Seventh Circuit very recently adopted the rule of contra proferentem to interpret ambiguous language in an ERISA plan. Phillips v. Lincoln National Life Insurance Co., 1992 WL 297985. It held that de novo review did not allow deference to any party's interpretation. The Seventh Circuit found that contra proferentem best advanced the interests and policies of ERISA. Id.

The rationales of the Second, Seventh and Ninth Circuits raise the important question of whether the contra proferentem rule should apply as state law under the saving clause of 29 U.S.C. § 1144(b)(2)(A), or whether it should apply under the "federal common law of rights and obligations under ERISA-regulated plans." Pilot Life Insurance Co. v. DeDeaux, 481 U.S. 41, 56 (1987). The Ninth Circuit thought the origin of the law did not matter while the Second and Seventh Circuits adopted the rule as federal common law.

Either of those rationales makes sense in this case. Minnesota, where this claim arose, has long applied the rule of contra proferentem when interpreting and regulating insurance claims. See, e.g., Olson v. St. Paul Fire & Marine Insurance Co., 43 Minn. 432, 29 N.W. 125 (1886); Caledonia Community Hospital v. St. Paul Fire & Marine Insurance Co., 239 N.W.2d 768, 770 (Minn. 1976). Alternatively, this Court's pre-ERISA decisions applying the contra proferentem rule and ERISA's policy of protecting plan participants also provides the basis for applying this rule of construction as federal common law.

III. THE QUESTION IS IMPORTANT AND SPECIAL.

The instant case demonstrates the decisive impact the Eighth Circuit's reliance requirement has on insurance claims under 29 U.S.C. §§ 1022 and 1132(a)(1). Because Neil Maxa is dead, the Maxa Estate cannot present evidence of Neil Maxa's understanding of the coordination of benefits provision. Were Neil Maxa available to testify, perhaps he would state that he understood that coordination of benefits provision meant that not more nor less than 100 percent of his expenses would be covered, as the last clause of that provision implies with misleading clarity.

The fact that Maxa cannot testify, however, dooms his estate's claim.

The same probative problem will exist with every claim where the plan participant is deceased. ERISA governs many types of benefits that are claimed post-mortem, including the health insurance benefits at issue here. Many life insurance benefits are also governed by ERISA, yet the strict drafting requirements of 29 U.S.C. § 1022(a)(1) would provide virtually no protection against misleading language. The participants will never be available to testify to their own interpretation when the claim becomes due. No matter how misleading and defective the summary plan description may be, the estates of deceased employee participants will be unable to prove claims under § 1022(a)(1).

The difficulties with proof of detrimental reliance extend beyond the claims of decedents' estates. In prosecuting claims, the average plan participants will be forced to testify to his or her interpretation of complicated language he or she may have read years earlier. Even if the participant studied the language carefully upon receiving the summary plan description, the honest participant may well have great difficultly recalling just what he or she understood when called to testify years later. If nothing else, requiring proof of reliance may penalize those who are forthright and admit they cannot recall what they may have read many years earlier.

Had the lower courts in this case applied contra proferentem, Maxa's Estate would have recovered benefits under John Alden's plan. The turbid diction of John Alden's coordination of benefits provision is not clearly understandable to the average plan participant as required by 29 U.S.C. § 1022(a). Both lower courts agreed, although each skirted the question of whether the language was truly ambiguous. The courts did not

need to decide that question since they found no evidence of reliance. Under this Court's de novo review, however, that issue can be decided. Applying contra proferentem, that ambiguity is resolved in favor of the Maxa Estate.

IV. THIS QUESTION IS RIPE FOR REVIEW.

While less than all the circuits have decided the question presented by this case, a wealth of case law exists applying the rule of contra proferentem to insurance claims. The Ninth Circuit noted:

> This rule of contra proferentem has been called "the most familiar expression in the reports of insurance cases."

Kunin v. Benefit Trust Life Insurance Co., 910 F.2d at 539, citing 2 G. Couch, R. Anderson, and M. Rhodes, Couch on Insurance 2d, § 15:874, at 334 (rev. ed. 1984). This court's own decisions applying the contra proferentem rule date back more than 100 years. First National Bank v. Hartford Insurance Co., 95 U.S. at 687-79. Virtually every state and the District of Columbia have applied this rule. 2 G. Couch et al., Section 15:83 at 399 n.4; 13 J. Appleman & J. Appleman, Insurance Law and Practice, § 7401 at 197 n.1 (rev. ed. 1976 & supp. 1989). This court has stated that the rule is "consistent with both reason and justice." Mutual Life Insurance Co. of New York v. Humi Packing Co., 263 U.S. at 174. With so many years of experience in so many jurisdictions, there is no reason to delay settlement of this issue and to bring uniformity among the circuits.

CONCLUSION

The question presented meets the criteria for review on writ of certiorari. The lower court's decision is in conflict with the principles stated in Firestone Tire & Rubber Co. v. Bruch. The question involves an important and special issue of federal law. The United States court of appeals decisions are in conflict with one another. The instant case raises important matters of federal policy for the Court's attention. For those reasons, this Petition should be granted.

Respectfully submitted,

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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

James Maxa, as the Personal Representative for the Estate of Neil Maxa,

Civil File No. 3-90-410

Plaintiff,

v.

MEMORANDUM AND ORDER

John Alden Life Insurance Company,

Defendant.

Stephen Tillitt, Esq., Gislason, Dosland, Hunter and Malecki, P. O. Box 5297, Minnetonka, MN 55343-2297, for plaintiff.

Patrick J. O'Connor, Jr., Esq., 2200 Norwest Center, 90 South Seventh Street, Minneapolis, MN 55402, for defendant.

This matter is before the court upon cross motions for summary judgment. For the reasons set forth below, plaintiff's motion is denied and defendant's motion is granted.

FACTS

This is an ERISA health insurance dispute. Plaintiff James Maxa seeks coverage for certain medical expenses incurred by his father, Neil, prior to his death. The denied benefits equal the amount Neil Maxa would have received had he applied for Medicare upon eligibility.

In July 1984 Neil Maxa, as president of H.R. Peterson Co., Inc. completed a request for participation in a group health plan insured through defendant. He was accepted as a covered employee. At that time he received several documents, including a certificate of group insurance, summarizing his rights and obligations under the plan. At issue here is the provision from the "Certificate of Group Insurance" upon which defendant relies to reduce the amount of Maxa's benefits.

> We will coordinate your medical and dental benefits with benefits payable under other plans. The other plans are those which provide benefits or services in connection with medical or dental care or treatment through:
>
> * * *
>
> (4) Medicare (Parts A & B) when you are eligible for Medicare coverage. For purposes of determining your Medicare benefits, you will be deemed to have enrolled for all coverages for which you are eligible under Medicare, whether or not you actually enroll.
>
> Coordination means that benefits are paid so that no more than 100% of your necessary, reasonable, and customary expenses will be covered under the combined benefits from all plans.

Neil Maxa also received a brochure which contains the following relevant language:

> Benefits may be reduced by the benefits payable under any other group-type insurance plan. The benefits of this plan will also be coordinated with the benefits available under Medicare (Parts A & B) when the individual becomes eligible for Medicare. The result of this provision will be that a person with coverage under more than one plan will not be entitled to receive benefits in an amount greater than 100

percent of the covered charges that are actually incurred.

There is no evidence on the record regarding Neil Maxa's reaction to these provisions other than the fact that he did not apply for Medicare. Plaintiff does not dispute that when Neil Maxa became eligible for Medicare at age 65 (he died at age 68), his premium was reduced from $210.00 to $134.90. Plaintiff further does not dispute that Neil Maxa, as president of the Peterson Company, was to be the administrator of the plan.

DISCUSSION

Under Fed. R. Civ. P. 56, summary judgment is appropriate where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Here there are three claims before the court. First, plaintiff claims the denied benefits on the theory that the plan description was faulty; second, plaintiff claims that defendant breached its fiduciary duty by failing to inform him of the need to enroll in Medicare at age 65; and third, plaintiff claims that the provision limiting benefits in the amount of available Medicare benefits is unlawful.

In interpreting the plan descriptions provided to Neil Maxa, the court is guided not by state-law rules of construction, but by ERISA itself. See Brewer v. Lincoln Nat. Ins. Co., 921 F.2d 150 (8th Cir. 1990).[1] Regarding plan description, ERISA requires the following:

The plan description and summary plan description shall contain the following information: the name and type of

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[1]To the extent plaintiffs's claims are not brought under ERISA, they are preempted.

administration of the plan . . . circumstances which may result in disqualification, ineligibility, or denial or loss of benefits.

29 U.S.C. § 1022(b) (emphasis added).

The required disclosure must be written in a manner calculated to be understood by the average plan participant. 29 U.S.C. § 1022 (a) (1) . The disclosure must not have the effect of "misleading, misinforming, or failing to inform" participants and beneficiaries of the relevant provisions, 29 C.F.R. § 2520. 102-2(b). Additionally, plan descriptions are not to use "technical jargon" and "long, complex sentences" and should make use of "clarifying examples and illustrations." 29 C.F.R. § 2520.102-3. "Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant." 29 C.F.R. § 2520.102-3.

"To secure relief on the basis of a faulty summary plan description, the claimant must show some significant reliance on, or possible prejudice flowing from the summary." Anderson v. Alpha Portland Industries, Inc., 836 F.2d 1512 (8th Cir. 1988) (citing Lee v. Union Electric Co., 789 F.2d 1303, 1308 (8th Cir. 1986), cert. denied, ___ U.S. ___, 107 S.Ct. 460 (1986)).

In the instant case, the court has grave doubts that the documents submitted to Neil Maxa met ERISA's requirements for plan summary descriptions regarding the coordination of Medicare benefits.[2] The materials are questionable because they arguably do not clearly state that a reduction to below 100% coverage is the consequence of the coordination policy. Defendant contends that

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[2]Defendant contends that Neil Maxa had the duty to provide the summary plan descriptions because he was the plan administrator. The court does not address this issue, however, because of the conclusion reached below.

the result necessarily and logically follows from the language in the documents, but that is not the standard of review. An example of such reduction or an explicit statement regarding reduction of coverage below 100% would, given the importance of the provision, be superior to the use of jargon such as "coordination" and one misleading example. Howard v. Gleason Corn., 716 F.Supp. 740 (W.D. N.Y. 1989), upon which defendant relies, is thus distinguishable. In Howard, the plaintiff had received clear notice that "if his employment was terminated, he must convert his policies to individual policies or run the risk of no coverage." 716 F.Supp. 744-45. Here the language is not as clear. Similarly, Stahl v. Tony's Bldg. Materials, Inc., 875 F.2d 1404 (9th Cir. 1989), carries little weight here because in that case "the description explained the rule applied to Stahl in perfectly understandable terms." 875 F.2d at 1408.

Despite the court's concerns about the plan descriptions, plaintiff's claim fails for lack of evidence that Neil Maxa relied on or was prejudiced by the descriptions. Anderson v. Alpha Portland Industries, Inc., 836 F.2d 1512 (8th Cir. 1988) controls here. In Anderson, similar to the instant case, the issue was whether certain retiree health and life benefits continued past retirement age and were vested for the lifetime of the retiree. 836 F.2d 1516. The plaintiffs maintained that a plan description failed to specify "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits" and, indeed, that the description guaranteed the benefits for life. 836 F.2d at 1520. The court concluded that the description was faulty because it failed to specify that the benefits were subject to expiration under the terms of plaintiffs' collective bargaining agreement, yet concluded that plaintiffs could not prevail. 836 F.2d at 1520. The reason plaintiffs could not prevail was the lack of evidence of detrimental

reliance on the misleading statement: "[L]ogically, evidence of detrimental reliance must show that plaintiffs took action, resulting in some detriment, that they would not otherwise have taken. Id.

Here, similarly, the evidence on the record does not support an inference of prejudice flowing from the descriptions or detrimental reliance on the descriptions. The court examines a record which includes the documents themselves, which are insufficient under Anderson, and the fact that premiums were reduced at age 65, which contravenes any suggestion of reliance.[3] Because plaintiff has not provided the court with sufficient evidence that Neil Maxa chose not to apply for Medicare due to the language in the plan descriptions, the "faulty summary" claim fails.

Plaintiff's remaining claims also fail as a matter of law. Even if defendant is assumed to be Neil Maxa's fiduciary under the plan, the breach of the fiduciary duty claim fails because there was no duty to provide individualized notice to each participant regarding the plan's coordination of benefits policy. In Stahl v. Tony's Bldg. Materials, Inc., 875 F.2d 1404, 1409 (9th Cir. 1989), the Ninth Circuit limited the scope of ERISA fiduciary duties as follows:

> We decline to rule, however that the Trust Fund's fiduciary duties required it to provide any individualized notice to Stahl. The Trust Fund, as shown above, adequately explained the rule that it applied to Stahl in its summary plan description. Even though compliance with the specific terms of ERISA does not eliminate all other fiduciary duties in all other situations, we decline to impose the disclosure

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[3]Plaintiff's citation of Monson v. Century Mfg. Co., 739 F.2d 1293 (8th Cir. 1984) for the proposition that reliance need not be proved is misplaced. Unlike Monson, this case does not involve repeated fraudulent representations. 739 F.2d at 1302.

> requirement that the Stahl's request. Not only do we lack evidence about the feasibility of providing such notice in this particular case, but to impose such a disclosure requirement would create a conflict with the Third and Seventh Circuits on an important national issue. See Cummings v. Briggs & Stratton Retirement Plan, 797 F.2d 383, 387 (7th Cir.) (summary plan description met ERISA's disclosure requirements and there was no duty to individually warn plan participants or beneficiaries), cert. denied 479 U.S. 1008, 107 S.Ct. 648, 93 L.Ed. 2d 703 (1986); Allen v. Atlantic Richfield Retirement Plan, 480 F.Supp. 848, 851-52 (E.D. Pa. 1979) (since summary plan description clearly warned employees of thirty day waiting period for election of benefits, and since there was no indication that Congress intended to impose any further duties on plan fiduciaries, trustees had fulfilled their fiduciary duties), aff'd, 633 F.2d 209 (3d Cir. 1980).

In the instant case the court has cast doubt on the descriptions given Neil Maxa regarding coordination of benefits. Plaintiff would distinguish the Stahl line of cases on this basis. But the court declines to require individualized notice here. Even if § 1022 was not complied with, there is no evidence on the record regarding the feasibility of individualized notice. Additionally, the possible failure of the plan descriptions to fully describe the coordination of benefits policy does not necessarily require the conclusion that individualized notice must be sent pursuant to a fiduciary duty. See Anderson, 836 F.2d at 1520 (although summary plan falsely stated that certain benefits were vested for the lifetime of the beneficiary, no fiduciary duty was breached when benefits were discontinued without notice). In short, the court declines to find a fiduciary duty on the basis of the evidence before it.

Finally, the plaintiff's argument that the coordination of benefits provision is void as a matter of law lacks merit.

Accordingly, IT IS ORDERED that:

1. Plaintiff's motion is DENIED.
2. Defendant's motion is GRANTED.
3. This case is DISMISSED.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: April 17, , 1991.

/s/ Paul A. Magnuson
Paul A. Magnuson
United States District Court Judge

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 91-2203MN

James Maxa, as the Personal Representative for the Estate of Neil Maxa,	*	
Appellant,	*	Appeal from the United States District Court for the
v.	*	District of Minnesota
John Alden Life Insurance Company,	*	
Appellee.	*	

Submitted: December 9, 1991

Filed: August 17, 1992

Before JOHN R. GIBSON, Circuit Judge, MAGILL, Circuit Judge, and KAUFMAN,* Senior District Judge.

KAUFMAN, Senior District Judge.

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*The HONORABLE FRANK A. KAUFMAN, Senior United States District Judge for the District of Maryland, sitting by designation.

In July of 1984, at the request of Neil Maxa ("Maxa"), as president of H.R. Peterson Co., Inc. ("Peterson"), John Alden Life Insurance Company ("John Alden") instituted a group health benefit plan for that company.[1] Maxa, then sixty-two years old, was accepted by John Alden for group health insurance coverage as an employee of Peterson and received, inter alia, a certificate of group insurance and a brochure, each of which outlined in some detail Maxa's rights and responsibilities under the group plan. When Maxa turned sixty-five years old, his insurance premium was reduced from $210.00 to $134.00. At that time, Maxa did not apply for any Medicare benefits. In early 1989, while still employed by Peterson, Maxa was hospitalized for an extended period of time. At the time of Maxa's death in June, 1989, a number of his medical and hospitalization bills remained outstanding. John Alden paid only some of those bills, claiming that it was not liable under the terms of the plan for the bills which Medicare would have covered if Maxa had enrolled for Medicare.

Maxa's son, James, as personal representative of his father's estate, commenced the within ERISA action against John Alden in September, 1990, alleging wrongful denial of medical benefits under 29 U.S.C. § 1132 (a) (1) (B), failure to provide an adequate summary plan description as required by 29 U.S.C. §

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[1]Judge Magnuson, in his Memorandum and Order dated April 17, 1991, from which plaintiff below appeals herein, stated that "[p]laintiff . . . does not dispute that Neil Maxa, as president of the Peterson Company, was to be the administrator of the plan." Memorandum and Order at 3 (April 17, 1991). On appeal, however, appellant James Maxa claims that "there was some question below on who is the plan administrator," and contends that John Alden is the plan administrator because ERISA so designates John Alden, and because John Alden prepared the plan documents and made claims decisions with regard to the plan. For the purposes of this appeal, this Court assumes arguendo only that, as asserted by James Maxa, John Alden is the proper plan administrator.

1022(a) (1), and breach of fiduciary duty as imposed by 29 U.S.C. § 1109(a). The parties filed cross-motions for summary judgment. In its summary judgment motion, the estate sought the benefits denied by John Alden on the grounds that (1) the summary plan description was faulty, (2) John Alden breached its fiduciary duty to Maxa by failing to notify him upon his sixty-fifth birthday that his plan benefits would be reduced by the amount of the Medicare coverage which he would receive if he were to apply for Medicare, and (3) the limitation which, John Alden maintains, reduces plan benefits by the amount of possible available Medicare benefits is unlawful.

The district court granted John Alden's motion for summary judgment, and denied the estate's motion for summary judgment, concluding that although the summary plan description may not have met the requirements of ERISA, plaintiff had not come forward with sufficient evidence of detrimental reliance by Maxa upon that description. The district court further declined to hold, upon the evidence presented below, that ERISA requires individualized notice of reduction of benefits. Finally, the district court found unpersuasive plaintiff's argument that the limitation of benefits provision at issue is void as a matter of law. In this appeal, the estate apparently seeks to have this Court reverse the district court's grant of summary judgment in favor of Alden and to remand this case to the district court with instructions to grant the estates' motion for summary judgment. In so doing, the only issues which the estate presses in this Court are those which relate to the three bases of the district court's grant of summary judgment in favor of John Alden.

The estate first maintains that none of the three sets of documents which Maxa received from John Alden should be considered a summary plan description. Although apparently none

of those documents was entitled "summary plan description," at least one of those documents, namely, the certificate of group insurance, provided a benefits summary which is the equivalent of a summary plan description.[2]

Appellant further contends that the following provision in John Alden's certificate of group insurance fails to meet the requirements of 29 U.S.C. § 1022(a)(1):

> COORDINATION OF BENEFITS
>
> We will coordinate your Medical and Dental Benefits (if applicable) with benefits payable under other plans. The other plans are those which provide benefits or services in connection with medical or dental care or treatment through:
>
> . . . .
>
> 4. Medicare (Parts A & B) when you are eligible for Medicare coverage. For purposes of determining your Medicare benefits, you will be deemed to have enrolled for all coverages for which you are eligible under Medicare (Parts A and B), whether or not you actually enroll.
>
> Coordination means that benefits are paid so that no more than 100% of your necessary, reasonable, and customary expenses will be covered under the combined benefits

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[2]It appears from the record that John Alden typically sends to an employer a form entitled "Summary Plan Description" to which the employer or administrator of the plan is supposed to attach the certificate of group insurance. The parties dispute whether John Alden delivered such a form to Neil Maxa as president of Peterson.

from all plans.[3]

Appellant claims that while, under the above-quoted provision, a plan participant may not collect benefits which have already been provided by Medicare, the wording of that provision does not require that plan benefits be reduced by the amount of payments which could have been, but have not been, received from Medicare. In the alternative, the estate argues that the said "COORDINATION OF BENEFITS" provision is ambiguous and therefore (1) should be construed against John Alden under the doctrine of contra proferentum, and/or (2) cannot be enforced against the estate because Maxa detrimentally relied upon or was prejudiced by that ambiguous provision.

This Court, in reviewing the district court's grant of

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[3]Another of the documents which Neil Maxa received is a brochure entitled North Star Employers Trust which states inter alia:

> Special Features and Limitations
>
> . . . .
>
> 3. Benefits may be reduced by the benefits payable under any other group-type insurance plan. The benefits of this Plan will also be coordinated with the benefits available under Medicare (Parts A & B) when the individual becomes eligible for Medicare. See GENERAL INFORMATION - Coordination of Benefits.
>
> . . . .
>
> Coordination of Benefits
>
> The Plan contains a provision which coordinates the Medical and Dental Benefits provided with any other benefits to which a person may be entitled under any other group-type insurance or medical care plan, including Medicare (Parts A & B) when the person becomes eligible under Medicare. The result of this provision will be that a person with coverage under more than one plan will not be entitled to receive benefits in an amount greater than 100% of the covered charges that are actually incurred.

summary judgment, determines de novo whether summary judgment is properly granted, Lone Ranger Television v. ProGram Radio Corp., 740 F.2d 718, 720 (9th Cir. 1984), and may consider only the record before the district court at the time the summary judgment ruling was made. See 10 Charles A. Wright et al., Fed. Prac. and Proc. § 2716 at 650-654 (1983). The court below made its summary judgment determinations on the basis of the record before it after both parties had full opportunity to present appropriate materials and arguments in accordance with Federal Rule of Civil Procedure 56. In such a context, "the inferences to be drawn from the underlying facts . . . must be viewed in the light most favorable to the party opposing the motion.'" Matsushita Elec. Industrial Co. v. Zenith Radio Corp., 475 U.S. 574, 587-88 (1986) (quoting United States v. Diebold, Inc., 369 U.S. 654, 655 (1962)).[4] Here, however, there were criss-cross summary judgment motions. See generally 10A Charles A. Wright, et al., supra § 2720 (1983). While the opponent of each such motion may be entitled to certain factual inferences running in its favor, in this instance we will consider the appeal on the basis of giving to the estate, the plaintiff-appellant, the benefit of all reasonable factual inferences, and will also give full effect to the following command of the Supreme Court:

> [A] denial of benefits challenged under § 1132(a) (1) (B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary

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[4]"[T]he plain language of Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden at trial." Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). "One of the principal purposes of the summary judgment rule is to isolate and dispose of factually unsupported claims or defenses . . . " Id. at 323-24.

discretionary authority to determine eligibility for benefits or to construe the terms of the plan.

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). The plan herein does not confer upon the administrator or fiduciary any such discretion. Accordingly, the review herein by this Court will be conducted de novo. In so doing, this Court, in interpreting the benefit plan at issue, will look first to a combination of the ERISA statute itself and of related federal common law, and then will move to a consideration of state law only "if [the state law] is [not] contrary to the provisions of ERISA." Brewer v. Lincoln National Life Insurance Co., 921 F.2d 150, 153, 154 (8th Cir. 1990).

I.

Summary Plan Description

ERISA sets forth the relevant requirements for a proper summary plan description in the following terms:

> **§ 1022. Plan description and summary plan description**
>
> (a) (1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries . . . The summary plan description shall include the information described in section (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. . .
>
> . . . .
>
> (b) The plan description and summary plan description shall contain the following information: . . . circumstances which may result in disqualification, ineligibility, or denial or loss of benefits . . .

29 U.S.C. § 1022(a) (1), (b) (1975). Pursuant to 29 U.S.C. § 1135, the Secretary of Labor is empowered to prescribe necessary regulations and forms. Pursuant to that power, regulations promulgated by the Secretary state that

> [t]he format of the summary plan description must not have the effect of misleading, misinforming or failing to inform participants and beneficiaries. Any description of exceptions, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure, or otherwise made to appear unimportant. .

29 C.F.R. § 2520.102-2(b) (1991). Those regulations also recommend, in certain circumstances, the use of "clarifying examples" and the avoidance of "technical jargon" and complex sentences. 29 C.F.R. § 2520.102-2(a) (1991).

Taken in its entirety, the "COORDINATION OF BENEFITS" provision in the plan at issue, as quoted supra, is not crystal clear, but can reasonably be read to imply that benefit coverage will be reduced by the amount of Medicare coverage for which one is eligible. That provision does not unambiguously state, as appellant urges, that only the receipt of duplicative benefits are prohibited. On the other hand, this Court, like the trial court, doubts whether the summary plan description meets the requirements of ERISA and its attendant regulations. Nevertheless, those doubts alone do not entitle the estate to victory, because in order "[t]o secure relief on the basis of a faulty summary plan description, the claimant must show some significant reliance on, or possible prejudice flowing from the summary." Anderson v. Alpha Portland Industries, Inc., 836 F.2d 1512, 1520 (8th Cir. 1988) (quoting Lee v. Union Electric Co., 789 F.2d 1303, 1308 (8th Cir.), cert. denied, 479 U.S. 962 (1986)).

Appellant takes the position that the estate was prejudiced by having to pay substantial unreimbursed medical expenses and

contends that Maxa's detrimental reliance upon that plan may be inferred as a matter of law from the facts of this case. Maxa's estate certainly appears to have suffered a loss because Maxa failed to enroll in Medicare. However, in order to recover for a faulty plan summary, appellant must demonstrate that the plan description caused the estate's decedent not to apply for Medicare. Anderson, 836 F.2d at 1520. "[E]vidence of detrimental reliance must show that the plaintiff [] took action, resulting in some detriment, that [he] would not have taken had [he] known [that the terms of the plan were otherwise]," Monson v. Century Mfg. Co., 739 F.2d 1293, 1302 (8th Cir. 1984), or that he failed, to his detriment, to take action that he would have taken had he known that the terms of the plans were otherwise. Appellant neither provided nor proffered below, or for that matter even in this Court, any direct evidence that Maxa failed to enroll in Medicare because of the language of the plan summary. Further, the facts of this case are not like those of Monson, in which detrimental reliance by the participants was inferred because the plan administrators clearly and repeatedly represented, in oral and written communications, that the terms of the profit-sharing plan therein at issue were contrary to the terms actually being enforced. Here, the plan description provided by the certificate of group insurance--while arguably not as clear as it could have been with regard to whether application for Medicare was absolutely necessary to assure total coverage--enabled a reasonable participant to conclude that he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits, and, at the very least, did not suggest to a reasonable reader that there was no need to apply for Medicare. Moreover, the reduction of Neil Maxa's premiums from $210.00 to $134.00 undercuts the estate's argument of detrimental reliance because it should have brought to the attention of a reasonable

participant in Neil Maxa's shoes the possibility that his benefits had been reduced.

We also note that we are bound by this Court's earlier holding in Brewer that "the contra insurer rule [i.e., the doctrine of contra proferentum] does not regulate insurance and is preempted by ERISA." 921 F.2d at 153. That rule "requir[es] that ambiguities in insurance contracts be resolved in favor of the insured. . . Id. However, as Brewer states, that "rule of construction violates the provisions of ERISA and thus cannot be used to interpret the plan's terms." Id.

II.

Individualized Notice

Appellant contends that John Alden breached its fiduciary duty under 29 U.S.C. § 1104(a)[5] by failing to notify Maxa on his sixty-fifth birthday that his benefits would be reduced and that he needed to enroll in Medicare in order to have full medical

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[5]Section 1104 states in pertinent part:

> (1) . . . a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and --
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.
>
> . . . . .

coverage.[6] The great majority of courts, however, have not imposed upon an ERISA plan fiduciary the duty individually to notify participants and/or beneficiaries of the specific impact of the general terms of the plan upon them. As the Ninth Circuit concluded in Stahl v. Tony's Bldg. Materials, Inc.:

> Stahl contends that the Trust Fund had the duty to warn him individually prior to expiration of the collective bargaining agreement that the expiration would put his past service credits in jeopardy. ERISA contains no provision requiring pension plan administrators to provide notice to plan participants other than the disclosure provisions of 29 U.S.C. §§ 1021(a) (1) and 1022(1982), regarding the requirement of publishing a summary plan description. However, as fiduciaries, the duties of plan administrators go beyond those specified in the statute, and include duties derived from common law trust principles.
>
> We decline to rule, however, that the Trust Fund's fiduciary duties required it to provide any individualized notice to Stahl. The Trust Fund . . . adequately explained the rule that it applied to Stahl in its summary plan description. Even though compliance with the specific terms of ERISA does not eliminate all other fiduciary duties in all other situations, we decline to impose the disclosure requirement that the Stahls request. Not only do we lack evidence about the feasibility of providing such notice in this particular case, but to impose such a disclosure requirement would create a conflict with the Third and Seventh Circuits on an important national issue. See Cummings v. Briggs & Stratton Retirement Plan, 797 F.2d 383, 387 (7th Cir.) (summary plan description met ERISA's disclosure requirements and there was no duty to

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[6]We assume, arguendo only, for the purpose of this appeal that John Alden was both a fiduciary and an administrator with respect to the benefits plan at issue. See supra n.1.

> individually warn plan participants or beneficiaries), cert. denied, 479 U.S. 1008, 107 S.Ct. 648, 93 L.Ed. 2d 703 (1986); Allen v. Atlantic Richfield Retirement Plan, 480 F. Supp. 848, 851-52 (E.D. Pa. 1979) (since summary plan description clearly warned employees of thirty-day waiting period for election of benefits, and since there was no indication that Congress intended to impose any further duties on plan fiduciaries, trustees had fulfilled their fiduciary duties), aff'd, 633 F.2d 209 (3d Cir. 1980).

875 F.2d 1404, 1409-10 (8th Cir. 1989) (emphasis added) (footnote omitted). To the same effect, see Childers v. Northwest Airlines, Inc.:

> Courts that have considered the applicability of [Section 1104] to notice-related claims have held that § 1104 does not impose a fiduciary duty to provide individualized notice of the effect a particular event may have on a participant or beneficiary's eligibility to receive benefits. [Citations]. The rationale for this holding is that fiduciaries should be able to rely upon the detailed and uniform guidance ERISA provides with regard to disclosure requirements rather than bearing the practically impossible burden of anticipating, and comprehensively addressing, the individualized concerns of thousands of employees, especially without notice of those concerns.

688 F. Supp. 1357, 1361 (D. Minn. 1988) (emphasis added). See also Howard v. Gleason Corp., 716 F. Supp. 740, 744-45 (W.D.N.Y. 1989) (stating that "it would have been a good idea for an employer to include a printed notice of an employee's conversion option with his or her final paycheck. Unfortunately, that responsibility is not mandated by the ERISA. That may be a matter for Congress to consider.")

Under the circumstances of this case, this Court does not construe ERISA or the regulations under it to require that the appellee had a duty individually to warn, upon their sixty-fifth

birthdays, each and all of the members of the plans which it insured that their benefits would be reduced according to the plan's coordination of benefits provision unless they enrolled in Medicare. Appellant has not provided any evidence concerning the feasibility of requiring John Alden to supply such notice. Moreover, on the facts of this case, the arguable ambiguity of the coordination of benefits provision at issue does not require a reviewing court, in order to achieve a fair result, to visit from hindsight upon the administrator and/or the fiduciary the requirement of individual notice.

III.

Void Against Public Policy

Appellant claims that appellee's coordination of benefits policy violates 42 U.S.C. § 1395y(b)(3)(A)(i) and that appellant may therefore seek double damages for its unreimbursed medical expenses under 42 U.S.C. § 1395y(b)(5). Appellant argues that Congress, through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), amended the Social Security Act, as shown by 1395y(b) (3) (A) (i) and (b) (5), so as to make Medicare the secondary payor where an employee is covered under a group health plan.

Section 1395y(b)(3)(A)(i) states:

> Payment [of Medicare] under this subchapter may not be made, except as provided in clause (ii), with respect to any item or service furnished in any month during the period described in clause (iii) to an individual (or to the spouse of such individual) who is employed at the time such item or service is furnished to the extent that payment with respect to expenses for such item or service has been made, or can reasonably be expected to be made, under a

> group health plan (as defined by clause (iv)) under which such individual is covered by reason of such employment.

42 U.S.C. § 1395y(b) (3) (A) (i) (1988). Section 1395y(b) (5) states:

> There is hereby created a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a workmen's compensation law or plan, . . . group health plan, or large group health plan which is made a primary payor under paragraph (1), (2), (3), or (4), respectively, and which fails to provide for primary payment (or appropriate reimbursement) in accordance with such respective paragraphs.

42 U.S.C. § 1395y(b) (5) (1988).

Appellant asserts that Alden's coordination policy contravenes the above-quoted provisions of the Social Security Act. But those provisions, by their plain meaning, do not prohibit such a plan policy. Nor has appellant provided any case law or legislative history which supports its suggested reading of the Social Security Act. Assuming arguendo only, however, that appellant is correct concerning the import of Section 1395y, the legislative history of the 1988 TEFRA amendments, which appellant claims amended the Social Security Act to ban a coordination policy such as that of John Alden, shows that Congress did not intend those amendments to apply to "any employer health benefits plan offered by employers employing less than 20 full-time employees." Pub. L. No. 97-248, 97th Cong., 2d Sess. (1982), reprinted in 2 U.S.C.C.A.N., 1982, at 793 (1982). In this case the record reveals--and appellant has not denied--that Peterson employed less than twenty individuals, i.e. approximately five. Thus, the following comment in the Senate Report,

accompanying the legislation relied upon by appellant, is applicable:

> The committee believe[d] that changes in the primacy relationship between Medicare and employer-based plans should not extend to small businesses, which often employ many older workers as a significant part of their total work force. Increases in the fringe benefit costs of these employers could discourage them from continuing to hire or to retain older workers in their jobs.

Id. Moreover, in 1990, Congress explicitly excluded the group health plan of a small employer from the reach of Section 1395y. See 42 U.S.C. § 1395y(b) (l) (A) (ii) (1990). Thus, it appears that Section 1395y does not apply to the group health plan which was provided to Peterson by Alden. Accordingly, appellant's argument that the coordination policy is void as contrary to Section 1395y is without merit.

IV.

Conclusion

For the reasons stated in this opinion, the district court's grant of summary judgment in favor of defendant/appellee is hereby affirmed.

AFFIRMED

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

(2)

Supreme Court, U.S.
FILED
DEC 16 1992
OFFICE OF THE CLERK

No. 92-881

In The
Supreme Court of the United States
October Term, 1992

JAMES MAXA AS PERSONAL REPRESENTATIVE
FOR THE ESTATE OF NEIL MAXA,

Petitioner,

vs.

JOHN ALDEN LIFE INSURANCE COMPANY,

Respondent.

On Petition for Writ of Certiorari to The United States Court of Appeals for the Eighth Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Whether the Court below correctly decided that Petitioner, in seeking to recover health benefits on allegations of a faulty summary plan description governed by ERISA 29 U.S.C. § 1001, *et seq.*, had to establish detrimental reliance on the plan summary.

PARTIES

Petitioner is James Maxa, as personal representative for the estate of Neil Maxa.

Respondent is John Alden Life Insurance Company, whose immediate parent is Houston National Life Insurance Company, which in turn, is wholly owned by John Alden Financial Corporation. John Alden Life Insurance Company has no subsidiaries other than wholly-owned subsidiaries, except for the Preferred Management Life Insurance Company.

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No. 92-881

In The

Supreme Court of the United States

October Term, 1992

JAMES MAXA, AS PERSONAL REPRESENTATIVE FOR THE ESTATE OF NEIL MAXA,

Petitioner,

vs.

JOHN ALDEN LIFE INSURANCE COMPANY,

Respondent.

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondent, John Alden Life Insurance Company ("John Alden"), submits this brief in opposition to Petitioner James Maxa's request that this Court issue a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit.

STATEMENT OF THE CASE

This action involves a claim for medical benefits under a group health plan insured through John Alden and governed by ERISA, 29 U.S.C. § 1001, *et seq.*

In July 1984, Neil Maxa, the president of H.R. Peterson Co., Inc., ("H.R. Peterson"), completed a request for participation in a group health benefit plan insured through John Alden. H.R. Peterson was accepted as a participating employer in the group health plan and, subsequently, Neil Maxa and his spouse were provided group health coverage as employees of H.R. Peterson. Neil Maxa was 62 years old when he enrolled for coverage with John Alden.

At the time Neil Maxa became an insured under John Alden's group health plan, he received a certificate of group insurance setting forth his rights and obligations under the plan. This group health certificate contained a coordination of benefits provision which reads, in pertinent part, as follows:

> We [John Alden] will coordinate your medical and dental benefits (if applicable) with benefits payable under other plans. The other plans are those which provide benefits or services in connection with medical or dental care or treatment through:
>
> (1) Group, blanket or franchise insurance (other than school accident policies);
>
> (2) Group hospital or medical service organizations, group practice, or other prepayment coverage on a group basis;

(3) A labor management trustee plan, union welfare plan, employer or employee benefit plan, or other arrangement of benefits for individuals of a group;

(4) Medicare (Parts A & B) when you are eligible for medicare coverage. For purposes of determining your Medicare benefits, you will be deemed to have enrolled for all coverages for which you are eligible under Medicare (Parts A & B), whether or not you actually enroll.

Coordination means that benefits are paid so that no more than 100% of your necessary, reasonable, and customary expenses will be covered under the combined benefits of all plans.

When Neil Maxa attained the age of 65, his insurance premium was reduced from $210 to $134.90. Neil Maxa failed to make application for either Medicare Part A or Medicare Part B before he died in June 1989, at the age of 68. At the time of his death, a number of medical bills remained outstanding. John Alden made its share of payments to various medical providers after coordinating benefits with Medicare. Because Neil Maxa failed to enroll in Medicare, various medical bills remained outstanding. John Alden declined James Maxa's requests, on behalf of Neil Maxa's estate, that it forego coordinating Neil Maxa's group health benefits with Medicare, and this litigation ensued.

On July 17, 1990, James Maxa filed this action in the Federal District Court for the District of Minnesota, alleging jurisdiction under 29 U.S.C. § 1132(a)(1). In his Complaint, James Maxa alleged, among other things, that the estate was entitled to medical benefits because the summary plan description was inadequate and in violation of § 102(a)(1) of ERISA, 29 U.S.C. 1022(a)(1).

On March 1, 1991, James Maxa and John Alden made cross motions for summary judgment. In a Memorandum and Order dated April 17, 1991, the Honorable Paul A. Magnuson, denied James Maxa's motion for summary judgment and granted John Alden's cross-motion for summary judgment and dismissed James Maxa's case. On May 16, 1991, James Maxa appealed from the judgment entered pursuant to Judge Magnuson's Memorandum and Order dated April 17, 1991. On August 17, 1992, the United States Court of Appeals, Eighth Circuit, affirmed the District Court's grant of summary judgment in favor of John Alden. Maxa v. John Alden Life Insurance Company, 972 F.2d 980 (8th Cir. 1992).

ARGUMENT

I. THE QUESTION PRESENTED WAS CORRECTLY DECIDED BELOW IN ACCORDANCE WITH WELL AND WIDELY-ESTABLISHED PRECEDENT.

Petitioner ("James Maxa") seeks to eliminate the element of detrimental reliance from a claim for welfare benefits premised upon a faulty ERISA plan summary. In essence, Petitioner requests a ruling that insurers of ERISA welfare benefit plans are strictly liable for claimed benefits solely upon a showing that the plan summary failed to meet the requirements of ERISA and its attendant regulations. In other words, James Maxa seeks to be relieved of the responsibility of establishing that the alleged faulty plan summary in any way caused the harm for which benefits are being sought.

In the instant case, James Maxa has established no nexus between the harm caused by Neil Maxa's failure to enroll in Medicare and the purportedly faulty summary plan description. Without establishing such a nexus, James Maxa has proved nothing more than that the estate suffered a loss because of Neil Maxa's failure to enroll in Medicare. James Maxa's attempt to be relieved of the responsibility of showing some causal relation between what he alleges to have been wrong with the summary plan and the harm suffered by the estate would convert ERISA into a form of strict liability law.

The Court of Appeals and the District Court, citing a long and consistent line of authority from the Eighth Circuit,

rejected the petitioner's argument. (A. 16-17 and A. 4-5.) The requirement that a plaintiff establish that he took action, resulting in some detriment, that he would not have taken had he known the terms of the plan were otherwise, has been a long-established element of a claim for relief on the basis of a faulty plan summary. Anderson v. Alpha Portland Industries, Inc., 836 F.2d 1512, 1520 (8th Cir. 1988); Lee v. Union Electric Co., 789 F.2d 1303, 1308 (8th Cir.) *cert. denied*, 479 U.S. 962 (1986); Monson v. Century Mfg. Co., 739 F.2d 1293, 1302 (8th Cir. 1984). In some instances, detrimental reliance by plan participants can be inferred from the nature and manner of representations made regarding the terms of the plan. Monson v. Century Mfg. Co., 739 F.2d 1293, 1302 (8th Cir. 1984). In this case, however, detrimental reliance could not be inferred as the plan summary, while arguably not as clear as it could have been, "enabled a reasonable participant to conclude that the he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits, and, at the very least, did not suggest to a reasonable reader that there was no reason to apply for Medicare." (A.17)

The conversion of ERISA into a strict liability statute has been rejected by the courts. The Eleventh Circuit, in another case in which an estate sought medical benefits based upon a faulty summary plan description, specifically rejected a strict liability standard for such claims. Branch v. G. Bernd Co., 955 F.2d 1574, 1578 (11th Cir. 1992). The element of detrimental reliance has been consistently applied in nearly all the federal circuits considering the issue. The

First and Third Circuits have held that beneficiaries who seek to enforce the terms of a faulty summary plan must show reliance on the summary. Bachelder v. Communications Satellite Corp., 837 F.2d 519, 522-23 (1st Cir. 1988) ("appellees cannot recover. . .because appellees did not show significant reliance or even the possibility of prejudice flowing from the [summary]"); Govoni v. Bricklayers, Masons, and Plasters Int'l Union Local No. 5 Pension Fund, 732 F.2d 250, 252 (1st Cir. 1984) ("[c]ase law suggests . . . that to secure relief, Govoni must show some significant reliance on, or possible prejudice flowing from, the faulty plan description"); Gridley v. Cleveland Pneumatic Co., 924 F.2d 1310, 1319 n.8 (3d Cir.), *cert. denied*, ___ U.S. ___, 111 S. Ct. 2856, 115 L.Ed.2d 1023 (1991). Similarly, the Fourth and Seventh Circuits also require a showing of reliance. Pierce v. Security Trust Life Ins. Co., 1992 W.L. 214042 (4th Cir. Va.); Black v. TIC Investment Corp., 900 F.2d 112, 115 (7th Cir. 1990).

In fact, only the Sixth Circuit has suggested that a beneficiary need not show reliance to enforce a summary's terms. Edwards v. State Farm Mut. Auto. Ins. Co., 851 F.2d 134 (6th Cir. 1988). In Edwards, the court found that the beneficiary had, in fact, relied upon the summary plan description; consequently, the suggestion that reliance is unnecessary is at best dictum. More importantly, however, Edwards involved a case where the summary plan description, by its terms, provided greater benefits than the plan. Consequently, the issue for the court was whether the terms of the plan, which the employee never received, would

prevail over the terms of the summary. The court concluded that the beneficiary had "been misled" by the summary and, therefore, the employer was unable to enforce the terms of its plan which were inconsistent with the summary. Id. at 136-137. Thus, at a minimum, Edwards stands for the proposition that a participant must at least establish that he or she has "been misled" by the summary. See also, Branch v. G. Bernd Co., 955 F.2d 1574 (11th Cir. 1992) (interpreting Edwards).

The instant case does not involve a claim for benefits based upon a plan summary which is inconsistent with the plan. Instead, petitioner seeks relief on the theory that John Alden's summary did not meet the requirements of ERISA and its attendant regulations. For example, petitioner argues that John Alden's summary does not use "commonly understood words" such as "reduced, diminished, or limited." (Petitioner's Brief at p.6.) The petitioner has not, and cannot, establish that James Maxa was misled by John Alden's summary. The Eighth Circuit, in interpreting John Alden's summary, found that while it was not "crystal clear," the summary could be "reasonably read to imply that benefit coverage will reduce by the amount of Medicare coverage for which one is eligible." (A.16) In other words, John Alden's summary was not misleading. The summary "did not suggest to a reasonable reader that there was no need to apply for Medicare." (A.17). In fact, John Alden's summary "enabled a reasonable participant to conclude that he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits." (A.17) Therefore, the Circuit Court

rejected the petitioner's interpretation that John Alden's coordination of benefits provision prohibits only the receipt of duplicative benefits. This rejection was sound as petitioner's interpretation requires one to ignore the very paragraph relating to Medicare coverage. (Paragraph 4 of the "Coordination of Benefits" provision.)

In essence, Petitioner's request of this Court to entertain this case would result only in the Court interpreting a particular summary plan's language for the purpose of determining whether one could reasonably conclude that it was unnecessary to enroll in Medicare. This language has already been interpreted by two courts and a third interpretation is unnecessary and, furthermore, is not important enough to warrant review.

II. THE DECISION BELOW IS NOT INCONSISTENT WITH THIS COURT'S PRECEDENT.

James Maxa argues that the Eighth Circuit's decision in this case is inconsistent with this court's opinion in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989). The argument appears to be that the Eighth Circuit's requirement of reliance results in deference to a participant's interpretation of plan language. Petitioner correctly interprets Bruch to be mean that "courts should not defer 'to either party's interpretation' when construing an ERISA governed plan." (Petitioner's Brief at p.9.) Yet, after providing this analysis of Bruch, petitioner then contends that his interpretation of the plan language should be given deference

under the *contra proferentem* rule of contract construction. (Petitioner's Brief at pp. 9-10.)

Petitioner's argument on this point is internally inconsistent. Moreover, Bruch cannot be read to absolve plan participants or beneficiaries from establishing that they relied to their detriment upon a faulty plan summary. The showing of reliance is an element separate and distinct from the proper interpretation of a plan or summary. The Eighth Circuit correctly acknowledged this Court's instructions in Bruch, and conducted its own *de novo* review. The court, in conducting its review, gave no deference to John Alden's interpretation of the summary nor deferred to petitioner's interpretation. Based upon its independent *de novo* examination, the Court of Appeals determined that, while John Alden's summary may not have met the technical requirements of ERISA, the language could reasonably be read to imply that benefit coverage will be reduced by the amount of Medicare coverage for which one is eligible. (A.16) The Circuit Court's determination that the petitioner had to establish that Neil Maxa relied to his detriment upon the summary's language is an element separate and distinct from the interpretation of the summary. This Court's decision in Bruch provides the lower court with instructions regarding the manner in which they are to construe the language of ERISA plans. This decision, however, cannot be understood to stand for the proposition that once plan language has been interpreted, it is unnecessary for participants or beneficiaries to establish that they relied to their detriment upon an adopted interpretation of the plan.

III. THE APPLICATION OF THE CONTRA PROFERENTEM RULE WOULD NOT CHANGE THE RESULT IN THIS CASE.

While the petitioner styles the question presented as one involving the necessity of reliance for ERISA benefits claims, he also discusses the application of the *contra proferentem* rule to ERISA plans as a justification for review. (Petitioner's Brief at pp. 10-15.) Petitioner claims that had the Eighth Circuit applied the *contra proferentem* rule in this case, the estate would have prevailed. (Petitioner's Brief at p. 14.) Petitioner contends that the Eighth Circuit failed to apply the *contra proferentem* rule because of its prior decision in Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150 (8th Cir. 1990). Petitioner claims that Brewer is in conflict with the decisions of the Second, Seventh and Ninth Circuits. (Petitioner's Brief at p. 10.)

The Eighth Circuit, however, does not reject the use of the *contra proferentem* rule in ERISA cases. In Delk v. Durham Life Ins. Co., 959 F.2d 104 (8th Cir. 1992), the court expressly adopted the use of the principle of *contra proferentem* in construing ambiguous plan language:

> After applying ordinary principles of interpretation to the plan at issue (citation omitted), the district court found the language of the plan ambiguous. When extrinsic evidence failed to resolve the ambiguities in the language, the court construed the language of the plan against Durham. In Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150, 153 (8th Cir. 1990), we held that the Missouri rule of construction that requires ambiguities to be construed in favor of the insured cannot be used in interpreting the terms of a

> plan governed by ERISA. There, we were able to resolve the ambiguity in the language by interpreting the language as would "an average plan participant" (citation omitted). The language at issue in Brewer ceased to be ambiguous when it was accorded its ordinary, and not specialized, meaning.
>
> Here, however, as the district court aptly demonstrated, the language remains ambiguous even after the applying the approach in the Brewer. Therefore, the district court correctly used the principle of *contra proferentem* and construed the ambiguous language against Durham. As a matter of federal common law, a court construing plans governed by ERISA should construe ambiguities against the drafter only if, after applying ordinary principles of construction, giving its language ordinary meaning and admitting extrinsic evidence, ambiguities remain.

Id. at 105-106.

In the instant case, the Eighth Circuit found the language of John Alden's summary "enabled a reasonable plan participant to conclude that he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits." (A.17) The Eighth Circuit expressly rejected petitioner's argument that the language could suggest "to a reasonable reader that there was no need to apply for Medicare." (A.17) Therefore, the *contra proferentem* would not aid petitioner because its interpretation was unreasonable. This is even more so the case when one considers extrinsic evidence such as that the participant's premiums were reduced from $210 to $134 at the time he attained the age of 65.

Therefore, this is not a situation wherein the court was confronted between choosing two reasonable interpretations based upon an ambiguity in plan language. Petitioner's interpretation was unreasonable. John Alden's summary, although not "crystal clear" and in technical compliance with ERISA, did "enable a reasonable participant to conclude that he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits."

In sum, the Eighth Circuit does not flatly reject the *contra proferentem* rule in ERISA cases and, therefore, the particular conflict that petitioner alludes to does not exist. This case does not present the proper vehicle for the examination of the issue of *contra proferentem* in ERISA litigation.

CONCLUSION

For all the reasons stated above, this court should deny James Maxa's Petition for Writ of Certiorari.

Dated: December 16, 1992

Respectfully submitted,

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